Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RHD MEMORIAL HOSPITAL
P MATHHEW O'NEIL
816 CONGRESS SUITE 1600
AUSTIN TX 78701

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-07-6476-01

MFDR Date Received
MAY 24, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "payment of at least 80% of the Hospital's usual and customary charges would constitute fair and reasonable payment, as this is consistent with the rates that other managed care payers pay the Hospital for inpatient medical services based on a percentage of the Hospital's charges."

Requestor's Supplemental Position Summary: "Please note since the MDR was filed by me, my contact information has changed…my client has received payment as described in the attached EOB. However my client disputes that the payment is proper or adequate pursuant to Division rules and my client disputes that the payment constitutes fair and reasonable payment under the Labor Code or any payer context for the reasons described above.

Amount in Dispute per Updated Table: $30,244.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The outpatient services for the above named claimant and date of service were billed as an outpatient bill type 131. Per the UB92, the claimant was in the facility over 23 hours. Texas Workers Compensation Acute Care Inpatient Hospital Fee Guidelines defines hospital Stays over 23 hours as an inpatient status therefore, these services should have been Billed as an inpatient status. The lines were priced to make payment per TWCC rules at the TX FS inpatient Surgical Per Diem plus Carve Out items at the TX FS rate, if any were billed. The type of bill was not changed and if the facility is a PPO provider the PPO discount has been applied. "

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2006 through June 6, 2006	Inpatient Hospital Services	$30,244.61	$164.58

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997 sets out the reimbursement guidelines for inpatient hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F286-Date(s) of service exceeds (95) day time period for submission per rule 408.027 and Bulletin No. B-0037-05A.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
   - U301-This item was previously submitted and reviewed with notification of decision issued to payor/provier (Duplicate Invoice).
   - X094-Charges included in the facility fee.
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
   - Z585-The charge for this procedure exceeds fair and reasonable.
   - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

Findings

1. On the initial explanation of benefits, the respondent denied reimbursement based upon timely filing the claim; however, upon reconsideration, the respondent did not maintain this position and issued payment of $935.42. Therefore, a timely filing issue does not exist in this dispute and the disputed services will be reviewed per applicable Division rules and guidelines.
2. The respondent states that "Per the UB92, the claimant was in the facility over 23 hours."

   The requestor states that "The carrier provides no evidence the patient was admitted over 23 hours other than its conclusory statement. Regardless, the patient was never admitted as an inpatient to the hospital."

   Former 28 Texas Administrative Code §134.401(b)(1)(B) defines inpatient services as "Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill indicates that claimant was admitted on June 5, 2006 at "06" hours and discharged on June 6, 2006 at "21" hours. Furthermore, the bill indicates "OBS DOU 1/HR" six units/hours and "OBS DOU ADD HR" and additional 22 units/hours were billed. This bill supports that claimant's length of stay exceeded 23 hours; therefore, the disputed services are subject to Former 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."

   A review of the submitted medical bill indicates that the requestor billed for one surgical date.
4. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore 1 multiplied by $1,118.00 = $1,118.00.

   A review of the submitted EOBs supports reimbursement of $953.42 for inpatient surgical services; therefore, per 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B) the requestor is due additional reimbursement of $164.58.

Conclusion

The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $164.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $164.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/30/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.